

		FOR OHF USE					

LL1

2000  
STATE OF ILLINOIS  
DEPARTMENT OF PUBLIC AID  
FINANCIAL AND STATISTICAL REPORT FOR  
LONG-TERM CARE FACILITIES  
(FISCAL YEAR 2000)

IMPORTANT NOTICE  
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<p>I. IDPH Facility ID Number: 0000786</p> <p>Facility Name: VERMILION MANOR NURSING HOME</p> <p>Address: 14792 CATLIN TILTON ROAD DANVILLE 61834 Number City Zip Code</p> <p>County: VERMILION</p> <p>Telephone Number: 217-443-6430 Fax # 217-443-1558</p> <p>IDPA ID Number: 37-6002224-001</p> <p>Date of Initial License for Current Owners: 01/01/74</p> <p>Type of Ownership:</p> <table><tr><td><input type="checkbox"/></td><td>VOLUNTARY, NON-PROFIT</td><td><input type="checkbox"/></td><td>PROPRIETARY</td><td><input checked="" type="checkbox"/></td><td>GOVERNMENTAL</td></tr><tr><td><input type="checkbox"/></td><td>Charitable Corp.</td><td><input type="checkbox"/></td><td>Individual</td><td><input type="checkbox"/></td><td>State</td></tr><tr><td><input type="checkbox"/></td><td>Trust</td><td><input type="checkbox"/></td><td>Partnership</td><td><input checked="" type="checkbox"/></td><td>County</td></tr><tr><td>IRS Exemption Code</td><td></td><td><input type="checkbox"/></td><td>Corporation</td><td><input type="checkbox"/></td><td>Other</td></tr><tr><td></td><td></td><td><input type="checkbox"/></td><td>"Sub-S" Corp.</td><td></td><td></td></tr><tr><td></td><td></td><td><input type="checkbox"/></td><td>Limited Liability Co.</td><td></td><td></td></tr><tr><td></td><td></td><td><input type="checkbox"/></td><td>Trust</td><td></td><td></td></tr><tr><td></td><td></td><td><input type="checkbox"/></td><td>Other</td><td></td><td></td></tr></table> <p>In the event there are further questions about this report, please contact: Name: EDIE HESSER Telephone Number: (217) 443-6430</p>	<input type="checkbox"/>	VOLUNTARY, NON-PROFIT	<input type="checkbox"/>	PROPRIETARY	<input checked="" type="checkbox"/>	GOVERNMENTAL	<input type="checkbox"/>	Charitable Corp.	<input type="checkbox"/>	Individual	<input type="checkbox"/>	State	<input type="checkbox"/>	Trust	<input type="checkbox"/>	Partnership	<input checked="" type="checkbox"/>	County	IRS Exemption Code		<input type="checkbox"/>	Corporation	<input type="checkbox"/>	Other			<input type="checkbox"/>	"Sub-S" Corp.					<input type="checkbox"/>	Limited Liability Co.					<input type="checkbox"/>	Trust					<input type="checkbox"/>	Other			<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from 12/01/99 to 11/30/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table><tr><td rowspan="3">Officer or Administrator of Provider</td><td>(Signed)</td><td></td><td>(Date)</td><td></td></tr><tr><td>(Type or Print Name)</td><td colspan="3">EDIE HESSER</td></tr><tr><td>(Title)</td><td colspan="3">ADMINISTRATOR</td></tr></table> <table><tr><td rowspan="4">Paid Preparer</td><td>(Signed)</td><td></td><td>(Date)</td><td></td></tr><tr><td>(Print Name and Title)</td><td colspan="3">SEE ATTACHED ACCOUNTANT'S REPORT</td></tr><tr><td>(Firm Name &amp; Address)</td><td colspan="3">CLIFTON GUNDERSON LLP 2 E. MAIN SUITE 120, DANVILLE, IL. 61832</td></tr><tr><td>(Telephone)</td><td>217-442-1643</td><td>Fax #</td><td>217-443-5470</td></tr></table> <p>MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed)		(Date)		(Type or Print Name)	EDIE HESSER			(Title)	ADMINISTRATOR			Paid Preparer	(Signed)		(Date)		(Print Name and Title)	SEE ATTACHED ACCOUNTANT'S REPORT			(Firm Name & Address)	CLIFTON GUNDERSON LLP 2 E. MAIN SUITE 120, DANVILLE, IL. 61832			(Telephone)	217-442-1643	Fax #	217-443-5470
<input type="checkbox"/>	VOLUNTARY, NON-PROFIT	<input type="checkbox"/>	PROPRIETARY	<input checked="" type="checkbox"/>	GOVERNMENTAL																																																																										
<input type="checkbox"/>	Charitable Corp.	<input type="checkbox"/>	Individual	<input type="checkbox"/>	State																																																																										
<input type="checkbox"/>	Trust	<input type="checkbox"/>	Partnership	<input checked="" type="checkbox"/>	County																																																																										
IRS Exemption Code		<input type="checkbox"/>	Corporation	<input type="checkbox"/>	Other																																																																										
		<input type="checkbox"/>	"Sub-S" Corp.																																																																												
		<input type="checkbox"/>	Limited Liability Co.																																																																												
		<input type="checkbox"/>	Trust																																																																												
		<input type="checkbox"/>	Other																																																																												
Officer or Administrator of Provider	(Signed)		(Date)																																																																												
	(Type or Print Name)	EDIE HESSER																																																																													
	(Title)	ADMINISTRATOR																																																																													
Paid Preparer	(Signed)		(Date)																																																																												
	(Print Name and Title)	SEE ATTACHED ACCOUNTANT'S REPORT																																																																													
	(Firm Name & Address)	CLIFTON GUNDERSON LLP 2 E. MAIN SUITE 120, DANVILLE, IL. 61832																																																																													
	(Telephone)	217-442-1643	Fax #	217-443-5470																																																																											

Facility Name & ID Number VERMILION MANOR NURSING HOME

# 0000786 Report Period Beginning: 12/01/99 Ending: 11/30/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	50	Skilled (SNF)	50	18,250	1
2		Skilled Pediatric (SNF/PED)			2
3	187	Intermediate (ICF)	187	68,255	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	237	TOTALS	237	86,505	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	3,681	366	2,667	6,714	8
9	SNF/PED					9
10	ICF	34,963	12,602	771	48,336	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	38,644	12,968	3,438	55,050	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 63.64%

D. How many bed-hold days during this year were paid by Public Aid? 0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy) N/A

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care? YES NO X

H. Does the BALANCE SHEET (page 17) reflect any non-care assets? YES NO X

I. On what date did you start providing long term care at this location? Date started 1/01/74

J. Was the facility purchased or leased after January 1, 1978? YES NO X

K. Was the facility certified for Medicare during the reporting year? YES X NO If YES, enter number of beds certified 17 and days of care provided 2,629

Medicare Intermediary

IV. ACCOUNTING BASIS

ACCRAUAL X MODIFIED CASH\* CASH\*

Is your fiscal year identical to your tax year? YES NO

Tax Year: N/A Fiscal Year: 12/01/99-11/30/00

\* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Facility Name & ID Number

VERMILION MANOR NURSING HOME

#

0000786

Report Period Beginning:

12/01/99

Ending:

11/30/00

Page 3

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	374,718	37,351	17,410	429,479		429,479		429,479			1
2	Food Purchase		284,858		284,858	(27,375)	257,483	(1,752)	255,731			2
3	Housekeeping	126,698	21,177		147,875		147,875		147,875			3
4	Laundry	92,289	13,734		106,023		106,023		106,023			4
5	Heat and Other Utilities			155,285	155,285	(283)	155,002	(4,741)	150,261			5
6	Maintenance	103,093	22,865	43,041	168,999		168,999		168,999			6
7	Other (specify):* WASTE DISPOSAL			12,991	12,991		12,991		12,991			7
8	TOTAL General Services	696,798	379,985	228,727	1,305,510	(27,658)	1,277,852	(6,493)	1,271,359			8
	B. Health Care and Programs											
9	Medical Director			24,000	24,000	(24,000)						9
10	Nursing and Medical Records	2,345,395	305,210	58,388	2,708,993	(18,290)	2,690,703		2,690,703			10
10a	Therapy			198,629	198,629	(2,097)	196,532		196,532			10a
11	Activities	123,835	665		124,500		124,500		124,500			11
12	Social Services	46,783	2,585		49,368		49,368		49,368			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,516,013	308,460	281,017	3,105,490	(44,387)	3,061,103		3,061,103			16
	C. General Administration											
17	Administrative	56,200			56,200		56,200		56,200			17
18	Directors Fees							4,169	4,169			18
19	Professional Services			13,150	13,150		13,150	3,500	16,650			19
20	Dues, Fees, Subscriptions & Promotions			12,039	12,039		12,039		12,039			20
21	Clerical & General Office Expenses	125,183	6,965	19,396	151,544		151,544	6,200	157,744			21
22	Employee Benefits & Payroll Taxes			467,535	467,535	27,375	494,910	4,687	499,597			22
23	Inservice Training & Education			2,706	2,706		2,706		2,706			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			2,888	2,888		2,888		2,888			25
26	Insurance-Prop.Liab.Malpractice			12,892	12,892		12,892		12,892			26
27	Other (specify):* BAD DEBT EXP			18,228	18,228		18,228	(18,228)				27
28	TOTAL General Administration	181,383	6,965	548,834	737,182	27,375	764,557	328	764,885			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,394,194	695,410	1,058,578	5,148,182	(44,670)	5,103,512	(6,165)	5,097,347			29

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.  
 NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			211,293	211,293		211,293		211,293			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			8,512	8,512		8,512		8,512			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			1,837	1,837		1,837		1,837			35
36	Other (specify):*											36
37	TOTAL Ownership			221,642	221,642		221,642		221,642			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					24,000	24,000		24,000			39
40	Barber and Beauty Shops					283	283		283			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			130,005	130,005		130,005		130,005			42
43	Other (specify):* EXCEPTIONAL CARE EXPENSES					20,387	20,387		20,387			43
44	TOTAL Special Cost Centers			130,005	130,005	44,670	174,675		174,675			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,394,194	695,410	1,410,225	5,499,829		5,499,829	(6,165)	5,493,664			45

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.  
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,752)	V2		4
5	Telephone, TV & Radio in Resident Rooms	(4,741)	V5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(18,228)	V27		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (24,721)		\$	30

OHF USE ONLY							
48		49		50		51	

B. If there are expenses experienced by the facility which do not appear in the  
general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	18,556		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 18,556		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B) )	\$ (6,165)		37

\*These costs are only allowable if they are necessary to meet minimum  
licensing standards. Attach a schedule detailing the items included  
on these lines.

C. Are the following expenses included in Sections A to D of pages 3  
and 4? If so, they should be reclassified into Section E. Please  
reference the line on which they appear before reclassification.  
(See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops	X		283	V5(3)	41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program	X		20,387	V10,V10a	44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$ 20,670		47

STATE OF ILLINOIS

VERMILION MANOR NURSING HOME

Report Period Beginning: ID# 0000786

Ending: 12/01/99

11/30/00

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1		\$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49				49
50				50
51				51
52				52
53				53

54				54
55				55
56				56
57				57
58				58
59				59
60				60
61				61
62				62
63				63
64				64
65				65
66				66
67				67
68				68
69				69
70				70
71				71
72				72
73				73
74				74
75				75
76				76
77				77
78				78
79				79
80				80
81				81
82				82
83				83
84				84
85				85
86				86
87				87
88				88
89				89
90	Total	0		90

## Summary A

11/30/00

[illegible]

## Summary B

11/30/00

[illegible]

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
N/A		N/A		VERMILION COUNTY	DANVILLE	COUNTY GOV'T

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V		NURSING HOME	\$			\$		1
2	V	18	COMMITTEE		VERMILION COUNTY	N/A	4,169	4,169	2
3	V	19	AUDIT		VERMILION COUNTY	N/A	3,500	3,500	3
4	V	21	ACCOUNTING/PAYROLL		VERMILION COUNTY	N/A	6,200	6,200	4
5	V	22	GROUP INSURANCE		VERMILION COUNTY	N/A	4,687	4,687	5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$ 18,556	\$ * 18,556	14

\* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1  Name	2  Title	3  Function	4  Ownership Interest	5  Compensation Received From Other Nursing Homes*	6  Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7  Compensation Included in Costs for this Reporting Period**		8  Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number VERMILION MANOR NURSING HOME # 0000786 Report Period Beginning: 12/01/99 Ending: 11/30/00

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐
- B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization VERMILION COUNTY, IL  
Street Address 6 N. VERMILION  
City / State / Zip Code DANVILLE, IL. 61832  
Phone Number ( 217) 431-2553  
Fax Number ( 217) 431-6714

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	18	NURSING HOME COMMITTEE		1		\$ 4,169	\$	1	\$ 4,169	1
2	19	AUDIT		1		3,500		1	3,500	2
3	21	ACCOUNTING/PAYROLL		1		6,200		1	6,200	3
4	22	GROUP INSURANCE		1		4,687		1	4,687	4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 18,556	\$		\$ 18,556	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1							\$		\$			\$	1
2													2
3													3
4													4
5													5
	Working Capital												
6	LOAN FROM COUNTY	X		OPERATING EXPENSES	N/A	1/01/97	200,000	183,384	N/A	0.0400	8,512		6
7													7
8													8
9	TOTAL Facility Related						\$ 200,000	\$ 183,384			\$ 8,512		9
	B. Non-Facility Related*												
10													10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$	\$			\$		14
15	TOTALS (line 9+line14)						\$ 200,000	\$ 183,384			\$ 8,512		15

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.  
(See instructions.)

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.  
(See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.			\$	N/A	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	N/A	2
3. Under or (over) accrual (line 2 minus line 1).			\$	N/A	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	N/A	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.			\$	N/A	5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$	N/A	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	N/A	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		1995	N/A	8	
		1996	N/A	9	
		1997	N/A	10	
		1998	N/A	11	
		1999	N/A	12	
			13	FOR OFF USE ONLY	
			13	FROM R. E. TAX STATEMENT FOR 1999 \$	13
			14	PLUS APPEAL COST FROM LINE 5 \$	14
			15	LESS REFUND FROM LINE 6 \$	15
			16	AMOUNT TO USE FOR RATE CALCULATION \$	16

NOTES:

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
This denial must be no more than four years old at the time the cost report is filed.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 74,800

B. General Construction Type: Exterior BRICKFrame SINGLE STORYNumber of Stories ONE

C. Does the Operating Entity?

☒ (a) Own the Facility

☐ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☒ (a) Own the Equipment

☐ (b) Rent equipment from a Related Organization.

☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES☒ NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	INFORMATION NOT AVAILABLE			\$	1
2					2
3	TOTALS			\$	3

**11/30/00**

**\*\*Improvement type must be detailed in order for the cost report to be considered complete.**

11/30/00

**B. Building Depreciation-Including Fixed Equipment.** (See instructions.) Round all numbers to nearest dollar.

**\*\*Improvement type must be detailed in order for the cost report to be considered complete.**

XI. OWNERSHIP COSTS (continued)
 B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9			
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4					\$	\$		\$	\$	\$	4	
5											5	
6											6	
7											7	
8											8	
	Improvement Type**											
9	EXHAUST SYSTEM			1996	5,346	535	10	535		2,629	9	
10	CONCRETE WORK-FRONT ENTRANCE			1996	1,050	70	15	70		309	10	
11	CANOPY			1996	19,619	1,308	15	1,308		5,450	11	
12	TILE REPLACEMENT			1996	1,128	113	10	113		452	12	
13	ROOF REPAIR			1997	30,645	1,532	20	1,532		5,235	13	
14	AIRCONDITIONERS			1997	15,322	766	20	766		2,490	14	
15	DRIVEWAY REPAIR			1997	2,900	290	10	290		967	15	
16	WATER HEATERS			1998	6,200	620	10	620		1,395	16	
17	CAPITAL IMPROVEMENT			1998	1,013	101	10	101		202	17	
18	ROOF REPAIR			1998	21,809	2,181	10	2,181		4,544	18	
19	AIR CONDITIONER UNITS			1998	9,160	458	20	458		954	19	
20	AIR CONDITIONER UNITS			1998	8,580	429	20	429		858	20	
21	AIR CONDITIONING UNITS			1999	49,921	2,496	20	2,496		3,328	21	
22	CANOPY REPAIR			1999	7,630	382	20	382		477	22	
23	NEW ROOF			1999	22,973	1,149	20	1,149		1,532	23	
24	GENERATOR			2000	7,951	232	20	232		232	24	
25	WATER HEATER			2000	8,368	139	20	139		139	25	
26	CONDENSER			2000	2,350	29	20	29		29	26	
27											27	
28											28	
29											29	
30											30	
31											31	
32											32	
33											33	
34											34	
35											35	
36	TOTAL (lines 4 thru 35)				\$ 221,965	\$ 12,830		\$ 12,830	\$	\$ 31,222	36	

\*Total beds on this schedule must agree with page 2.
 \*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)								
	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	\$412,282	\$53,037	\$53,037	\$	VARIOUS	\$292,680	37
38	Current Year Purchases	16,082	1,482	1,482		VARIOUS	1,482	38
39	Fully Depreciated Assets	475,586				VARIOUS	475,586	39
40								40
41	TOTALS	\$903,950	\$54,519	\$54,519	\$		\$769,748	41

D. Vehicle Depreciation (See instructions.)*									
	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9
42	RESIDENT TRANS	DODGE VAN 1989	1989	\$25,461	\$	\$	\$	5	\$25,461
43	RESIDENT TRANS	FORD VAN 1996	1996	22,296	4,459	4,459		5	19,323
44	MAINTENANCE	FORD TRUCK 1993	1993	19,169				5	19,169
45									
46	TOTALS			\$66,926	\$4,459	\$4,459	\$		\$63,953

E. Summary of Care-Related Assets				1	2
		Reference			Amount
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)			\$6,374,148
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)			\$211,293
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)			\$211,293
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)			\$
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)			\$4,010,156

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)				
	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4
52		\$	\$	\$
53				
54				
55				
56				
57	TOTALS	\$	\$	\$

G. Construction-in-Progress		
	Description	Cost
58		\$
59		
60		
61		\$

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?  
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

\*\*

8. List separately any amortization of lease expense included on page 4, line 34.  
This amount was calculated by dividing the total amount to be amortized  
by the length of the lease .
- 

9. Option to Buy: ☐ YES ☐ NO Terms: \*

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO
16. Rental Amount for movable equipment: \$ 1,837 Description: COPY MACHINES LEASED THROUGH MELLON FIRST  
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning

Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	\$
13.	/2002	\$
14.	/2003	\$

\* If there is an option to buy the building, please provide complete details on attached schedule.

\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER AIDE

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER AIDE

☐

☐

B. EXPENSES		ALLOCATION OF COSTS (d)			
		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED	
COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost						
					Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care	LINE 39(8)	52 visits			24,000		52	24,000	5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$		\$ 24,000	\$	52	\$ 24,000	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 394,424	\$	1
2	Cash-Patient Deposits	40,239		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 50,000 )	731,328		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,165,991	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	5,384,603		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	989,545		16
17	Accumulated Depreciation (book methods)	(4,010,156)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 2,363,992	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 3,529,983	\$	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 134,509	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	47,443		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	151,304		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<b>DUE TO OTHER FUNDS</b>	487,324		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 820,580	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 820,580	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 2,709,403	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 3,529,983	\$	48

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,815,661	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,815,661	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(106,258)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (106,258)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 2,709,403	24 *

\* This must agree with page 17, line 47.

**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.  
**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

1			
	Revenue	Amount	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 5,332,882	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 5,332,882	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
	<b>C. Other Operating Revenue</b>		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	1,752	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 1,752	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***	23,623	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 23,623	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>MISCELLANEOUS</b>	35,314	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 35,314	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 5,393,571	30

2			
	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	1,305,510	31
32	Health Care	3,105,490	32
33	General Administration	737,182	33
	<b>B. Capital Expense</b>		
34	Ownership	221,642	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers		35
36	Provider Participation Fee	130,005	36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 5,499,829	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(106,258)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (106,258)	43

\* This must agree with page 4, line 45, column 4.

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? N/A If not, please attach a reconciliation.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)  
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,938	2,104	\$ 40,982	\$ 19.48	1
2	Assistant Director of Nursing	1,755	1,896	36,043	19.01	2
3	Registered Nurses	24,899	26,244	472,751	18.01	3
4	Licensed Practical Nurses	48,722	52,040	699,269	13.44	4
5	Nurse Aides & Orderlies	106,539	114,807	1,024,969	8.93	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,921	2,113	19,816	9.38	9
10	Activity Assistants	8,956	10,373	69,544	6.70	10
11	Social Service Workers	5,462	5,889	46,783	7.94	11
12	Dietician					12
13	Food Service Supervisor	8,773	9,352	80,539	8.61	13
14	Head Cook	8,098	8,616	57,555	6.68	14
15	Cook Helpers/Assistants	31,581	33,903	236,624	6.98	15
16	Dishwashers					16
17	Maintenance Workers	8,342	8,909	103,093	11.57	17
18	Housekeepers	14,724	16,313	126,698	7.77	18
19	Laundry	11,766	12,953	92,289	7.12	19
20	Administrator	1,960	2,088	56,200	26.92	20
21	Assistant Administrator	1,022	1,097	9,735	8.87	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	14,091	15,309	115,448	7.54	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	1,971	2,219	34,475	15.54	29
30	Habilitation Aides (DD Homes)	6,762	7,395	71,381	9.65	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	309,282	333,620	\$ 3,394,194 *	\$ 10.17	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$ 17,410	1/3	35
36	Medical Director				36
37	Medical Records Consultant		3,310	10/3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		2,600	10/3	39
40	Physical Therapy Consultant		5,913	10/3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) <u>FR &amp; R</u>		12,975	19/3	46
47	<u>COMPUTER SUPPORT</u>		4,115	21/3	47
48	<u>CLIFTON GUNDERSON LLP</u>		175	19/3	48
49	TOTAL (lines 35 - 48)		\$ 46,498		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	179	\$ 6,416	10/3	50
51	Licensed Practical Nurses	617	18,377	10/3	51
52	Nurse Aides	1,156	19,432	10/3	52
53	TOTAL (lines 50 - 52)	1,952	\$ 44,225		53

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.





XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union?    YES, EXCEPT RN'S

(2) Are there any dues to nursing home associations included on the cost report?    NO  
If YES, give association name and amount. \_\_\_\_\_

(3) Did the nursing home make political contributions or payments to a political action organization?    NO    If YES, have these costs been properly adjusted out of the cost report?    N/A

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?    NO    If YES, what is the capacity?    N/A

(5) Have you properly capitalized all major repairs and equipment purchases?    YES  
What was the average life used for new equipment added during this period?    7

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.    \$    58,421    Line    10

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports?    YES    If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement?    NO  
If YES, give effective date of lease.    N/A

(9) Are you presently operating under a sublease agreement?    \_\_\_\_\_ YES    X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?    YES \_\_\_\_\_ NO    X    If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period.    \$    130,005  
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?    NO    If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V?    YES

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO    For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.    \$    27,375    Has any meal income been offset against related costs?    YES    Indicate the amount.    \$    1,752

(16) Travel and Transportation  
a. Are there costs included for out-of-state travel?    NO  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents?    NO    If YES, please indicate the amount of income earned from such a program during this reporting period.    \$    N/A  
c. What percent of all travel expense relates to transportation of nurses and patients?    75%  
d. Have vehicle usage logs been maintained?    YES  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use?    YES  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?    N/A  
**g. Does the facility transport residents to and from day training?    NO**  
**Indicate the amount of income earned from providing such transportation during this reporting period.    \$    N/A**

(17) Has an audit been performed by an independent certified public accounting firm?    YES  
Firm Name:    CLIFTON GUNDERSON LLP    The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached?    NO    If no, please explain.    SEE ATTACHMENTS

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V?    YES

(19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report?    N/A  
Attach invoices and a summary of services for all architect and appraisal fees.